Managing patients with a history of substance abuse

Christopher P. O'Brien MD CCFP FCFP

Matthew is a single, 48-year-old man. Having had a life troubled by bad relationships and drug abuse, he travels to Brazil where he successfully develops a new life with no drug use, a healthy same-sex relationship, and a career as a chef. Unfortunately this all changes when his partner is diagnosed with a life-limiting illness and Matthew begins using alcohol and prescription opioids again.

Matthew's partner dies in the spring of 2012, and his worsening unhealthy behaviour leads to job loss. There is no support system in Brazil or in Canada. He begins having seizures, headaches, and focal weakness. Attempts to seek medical care are hampered because he has no health insurance. Despite their frustration and disappointment with him, Matthew's family members pool resources and arrange travel to Canada where he is admitted to hospital.

His history reveals heavy smoking with a cough, hemoptysis, dyspnea, and chest pain at 4 out of 10, as well as lumbar pain at 7 out of 10. He experiences periods of confusion. On physical examination, he is cachectic, has tenderness to palpation of his lumbar region, and has weakness in his left extremities. Staff members are trying to avoid providing him with opioids, given his history of substance abuse.

Prescription opioid analgesics are an essential treatment option for all patients with moderate to severe pain. This is a core principle on which the World Health Organization has built its analgesic ladder. Its success is based on the efficient use of opioids in a carefully selected patient population.[1] However, substance abuse is increasingly more prevalent in the general population, and we are therefore encountering more patients with palliative illness and history of substance abuse.[2,3] Many clinicians believe they lack the knowledge and the necessary communication skills to address the needs of patients with addiction.[4] For this reason, they tend to undertreat pain in this population owing to misconceptions, biases, morals, and various education system gaps.[5] In the best interest of palliative patients with addiction and their families, it is a moral duty and obligation to both treat their pain and manage their addiction.[6]

La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro de mars 2014 à la page e160.

Box 1 outlines the principles to follow when prescribing controlled substances to patients with a history of substance abuse.

Identifying addiction

Computed tomographic scans reveal a right lung mass and right parietal brain metastasis; a bone scan suggests lumbar metastatic lesions. A bronchoscope and biopsy confirm a non–small cell lung cancer. Matthew is made aware of the diagnosis and palliative prognosis, and after consultation with oncology, he receives palliative radiotherapy to his brain, chest, and lumbar spine. He declines chemotherapy.

His discharge from the hospital to a special care home is expedited by a social worker. As his family physician, you make a home visit. You find that Matthew's caregivers are struggling with managing his symptoms and they explain that they are unsure if they can care

Box 1. Principles of prescribing controlled substances when there is a history of substance abuse

Adhere to the following principles when prescribing controlled substances to patients with a history of substance abuse:

- Ensure that 1 clinician is responsible for pain management prescriptions
- Have a written agreement that clearly documents the treatment plan, explains the roles and expectations of the team members and the patient, and outlines the consequences of aberrant drug-taking or diversion
- Include the patient's family so that patient support and supervision is increased
- Select 1 pharmacy; make the pharmacist part of the team
- Select the drug. Choose oral administration if possible. If the parenteral route is needed, continuous subcutaneous infusion is the route of choice. Use an opioid based on around-the-clock dosing or long-acting agents when possible
- Use nonopioid adjuvants when possible
- Use nonpharmacologic adjuvants when possible (relaxation therapy, music, guided imagery, biofeedback, etc)
- Limit the quantity of medication dispensed at any 1 time
- Conduct pill counts and request the return of used transdermal patches
- Include spot urine toxicology screening (this would be at the discretion of the physician, as it is not often done in the palliative setting)

for him. They have smelled marijuana on him and have witnessed "sketchy" people visiting.

Matthew uses a walker, requires the assistance of another person, has tachypnea on exertion, and has a score of 50% on the palliative performance scale, version 2.[7] He describes a sharp right chest pain at 5 out of 10 that is worse with inspiration or cough, and an aching lumbar region pain at 7 out of 10 that awakens him. He was discharged with 500 mg of naproxen sodium to take twice daily and was instructed to purchase acetaminophen if he needed something more. He was told he would not be given opioids for his pain because of his addiction and that his pain should subside about 2 weeks after radiotherapy.

Matthew admits to illicit drug use since discharge but believes he has had no other choice because he has been ignored, neglected, and left to suffer "just because I am an addict." You believe he needs urgent attention and will need opioids to manage his pain. You realize the complexity of this case necessitates an interdisciplinary approach. You consult your palliative care team (physician, social worker, clinical nurse specialist), as well as an addictions counselor.

Table 1 defines *addiction* (substance abuse) and provides some common facts about addictions.[2,4,8-11] Addiction is not to be confused with physical dependence, which is "the phenomenon of withdrawal when an opioid is abruptly discontinued or an opioid antagonist is administered."[8,9] The severity of opioid withdrawal is dependent on various factors: the opioid dose, the duration of use, and the previous exposure to opioids.

The concurrent management of substance abuse and pain in palliative patients is critical. It can help foster adherence to medical therapy and safety during treatment, and help minimize the risk of adverse interactions between illicit and prescribed treatment. While working on recovery, a patient can take responsibility and make amends for past actions, paving the road to a "good death." Recovery can also foster healing of broken or tenuous relationships with family members and friends, thus strengthening a patient's support network.[2]

To manage an addiction, one must first identify it in a patient. There are various validated tools available to assist in identifying a patient with a history of substance abuse (addiction), such as the CAGE (Have you ever felt that you should *cut* down on your drinking? Have people *annoyed* you by criticizing your drinking? Have you ever felt bad or *guilty* about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover [*eye*-opener]?), the CAGE-AID (CAGE Adapted to Include Drugs), and the ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) questionnaires.[12-14]

Prescribing principles

In an effort not to offend or upset patients, clinicians often avoid inquiring about drug abuse; however, it is vital to ask the question and obtain a detailed history of drug abuse. A nonjudgmental, empathetic, yet truthful dialogue is the best strategy.[2] If you anticipate defensiveness from patients, explain to them that you need to know details in order to help prevent withdrawal and so that you can prescribe the right drug at the proper dose to allow sufficient pain relief and eliminate any serious adverse events.

After completing your history (including a thorough history of substance abuse), a physical examination, and a review of investigations, you discuss a

Table 1. Description of and common facts about addiction

DESCRIPTION AND COMMON FACTS	EXPLANATION
Description	*Addiction* is defined as a chronic neurobiological disease influenced by various factors (hereditary, psychosocial, environmental, and spiritual) that contribute to its development and presentation[8,9]
	Addiction is characterized by 1 or more of the behaviour problems documented in the 4 Cs of addiction: loss of *control* over use; continued use despite *consequences*; *compulsion* to use; and *craving*[8,9]
Common facts	Annually, 20% of Canadians experience mental health or addiction problems, and about 20% of people with mental disorders have concurrent substance use[10]
	Many people with addiction are of lower socioeconomic status and are at risk of being alienated from the health care system
	Evidence indicates that patients with addiction are at increased risk of receiving inadequate pain management owing to health care providers' lack of knowledge about managing patients with addiction and their fear of exacerbating patients' addiction by prescribing opioids.[4,11] Effective pain management is an essential part of high-quality care in order to ensure quality of life. It is the right of all patients, whether they have addictions or not
	There is a lack of evidence regarding the risks of using controlled substances in terminally ill patients with a remote or current history of substance abuse. It is commonly accepted that patients with a medical illness complicated by pain and psychological distress are at greater risk of aberrant drug-related behaviour[2]

management plan with Matthew. You are direct with him about your concerns with his history of substance abuse and explain the value of an honest therapeutic relationship. He is aware that your management plan will involve an interdisciplinary team of experts.

To address Matthew's metastatic lumbar bone pain and what appears to be pleuritic chest pain, your strategy for pain management includes opioids. You clarify the goals of care, and you are clear on the principles you use when prescribing opioids to any patients with advanced illness and addiction (**Box 1**). *You prescribe hydromorphone, discontinue naproxen sodium, and initiate dexamethasone. You remind Matthew of the potential for his radiotherapy to have further analgesic effect, and advise him on nonpharmacologic adjuvants for his pain (eg, meditation, music therapy, therapeutic touch).*

After careful titration of his opioid and use of other pharmacologic and nonpharmacologic interventions, Matthew achieves good pain control. He has regained a sense of control and dignity and has earned trust and respect from some, but not all, of his family members and friends. His functional and cognitive status deteriorates rapidly, and he is admitted to a hospice. He continues to have good pain and symptom relief, and dies peacefully with family and friends at his bedside. His family members describe having the chance to reconnect with Matthew and having him back in their lives, even for only a short time, as a wonderful gift.

Dr O'Brien is a practising family physician in Saint John, NB.

Competing interests
None declared

References

1. World Health Organization. *Cancer pain relief: with a guide to opioid availability*. 2nd ed. Geneva, Switz: World Health Organization; 1996. Available from: **http://whqlibdoc.who.int/publications/9241544821.pdf**. Accessed 2014 Jan 31.
2. Kirsh KL, Passik SD. Palliative care in the terminally ill drug addict. *Cancer Invest* 2006;24(4):425-31.
3. Passik SD, Theobald DE. Managing addiction in advanced cancer patients: why bother? *J Pain Symptom Manage* 2000;19(3):229-34.
4. Childers JW, Arnold RM. "I feel uncomfortable 'calling a patient out'": educational needs of palliative medicine fellows in managing opioid misuse. *J Pain Symptom Manage* 2012;43(2):253-60. Epub 2011 Jun 15.
5. Grant MS, Cordts GA, Doberman DJ. Acute pain management in hospitalized patients with current opioid abuse. *Top Adv Pract Nurs eJ* 2007;7(1).
6. Craig DS. Are opioid risk evaluation and mitigation strategies (REMS) interrupting your sleep? *J Pain Palliat Care Pharmacother* 2012;26(2):134-5.
7. Victoria Hospice Society [website]. *Palliative performance scale (PPSv2) version 2*. Victoria, BC: Victoria Hospice Society; 2006. Available from: **www.victoriahospice.org/sites/default/files/imce/PPS%20ENGLISH.pdf.** Accessed 2014 Jan 31.
8. Brown SC, McGrath PA. Pain control. In: Hanks G, Cherny NI, Christakis NA, Fallon M, Kaasa S, Portenoy RK, editors. *Oxford textbook of palliative medicine*. 4th ed. New York, NY: Oxford University Press; 2010. p. 1330-1.
9. Thai V, Fainsinger RL. Pain. In: Emanuel LL, Librach LS, editors. *Palliative care: core skills and clinical competencies*. 2nd ed. St Louis, MO: Saunders; 2011. p. 100-1.
10. Centre for Addiction and Mental Health [website]. *Mental illness and addiction statistics*. Toronto, ON: Centre for Addiction and Mental Health; 2012. Available from: **www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/pages/addictionmentalhealthstatistics.aspx.** Accessed 2014 Jan 31.
11. Neerkin J, Cheung CC, Stirling C. *Guidelines for cancer pain management in substance misusers*. Nottingham, Engl: Palliativedrugs.com Ltd; 2011. Available from: **www.palliativedrugs.com/download/100615_Substance_misuse_pain_guidlines_final.pdf**. Accessed 2014 Jan 31.
12. Ewing JA. Detecting alcoholism. The CAGE questionnaire. *JAMA* 1984;252(14):1905-7.
13. Humeniuk RE, Henry-Edwards S, Ali RL, Poznyak V, Monteiro M. *The alcohol, smoking and substance involvement screening test (ASSIST): manual for use in primary care*. Geneva, Switz: World Health Organization; 2010. Available from: **http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf?ua=1**. Accessed 2014 Jan 31.
14. Brown RL, Rounds, LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wis Med J* 1995;94(3):135-40.

BOTTOM LINE

- Substance abuse is just as common in patients with life-limiting illnesses as in the general population.
- Be consistent in history taking and use tools (eg, CAGE, CAGE-AID, and ASSIST questionnaires) to identify patients with history of substance abuse.
- Managing pain in a patient with a life-limiting illness and a history of substance abuse is complicated and challenging, especially as use of controlled substances might be necessary; however, it is our moral duty to treat these patients. Use an interdisciplinary team approach, consisting of palliative medicine and addiction medicine expertise.
- Adhere to a set of prescribing principles when prescribing controlled substances to patients with a history of substance abuse so that you are consistent in the care of these patients.

Palliative Care Files is a quarterly series in *Canadian Family Physician* written by members of the Palliative Care Committee of the College of Family Physicians of Canada. The series explores common situations experienced by family physicians doing palliative care as part of their primary care practice. Please send any ideas for future articles to **palliative_care@cfpc.ca.**